



Report to the Committee on Armed
Services, U.S. Senate

July 2014

DEFENSE HEALTH CARE

US Family Health Plan is Duplicative and Should be Eliminated

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GAO Highlights

Highlights of [GAO-14-684](#), a report to the Committee on Armed Services, U.S. Senate

Why GAO Did This Study

DOD provides health care to about 9.6 million eligible beneficiaries through its TRICARE program. The department contracts with MCSCs to administer TRICARE's benefit options in three regions across the United States. Separately, DOD contracts with six USFHP designated providers to offer TRICARE Prime—the managed care option—to enrollees in certain locations across the country.

Senate Report 112-173, which accompanied a version of the National Defense Authorization Act for Fiscal Year 2013, mandated that GAO review DOD's health care contracts, citing concerns with the growing costs of these contracts, including the USFHP. For this report, GAO examined (1) the role of the USFHP within the MHS, and (2) the extent to which the USFHP affects DOD's health care costs. GAO analyzed information about the USFHP and the MCSCs, reviewed available USFHP cost data, and interviewed officials from DOD, the designated providers, and the MCSCs.

What GAO Recommends

Congress should terminate DOD's authority to contract with the USFHP designated providers in a manner consistent with a reasonable transition of affected USFHP enrollees into TRICARE's regional managed care program or other health care programs as appropriate. DOD confirmed that GAO's factual determinations about the USFHP are correct and agreed that this program is duplicative and results in unnecessary costs and other inefficiencies. DOD reiterated the importance of carefully transitioning USFHP enrollees to other health plans if the USFHP were eliminated.

View [GAO-14-684](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

July 2014

DEFENSE HEALTH CARE

US Family Health Plan is Duplicative and Should be Eliminated

What GAO Found

The role of the US Family Health Plan (USFHP) within the Department of Defense's (DOD) current military health system (MHS) is duplicative because it offers military beneficiaries the same TRICARE Prime benefit that is offered by the regional TRICARE managed care support contractors (MCSC). The USFHP is an association of six health care providers, referred to as designated providers, which took ownership and control of U.S. Public Health Service hospitals in 1982 when Congress enacted legislation that made these facilities part of DOD's health care system. During the implementation of TRICARE in the 1990s, Congress required the designated providers to offer the TRICARE Prime benefit to their enrollees. While the USFHP is a relatively small program—approximately 134,000 enrollees—there is significant overlap with the MCSCs in several key areas, including benefits, geographic service areas, and provider networks. For example, four of the six USFHP designated providers have more than 80 percent of their service area zip codes included in areas where the MCSCs offer TRICARE Prime. Furthermore, the USFHP remains a distinct statutory program that is not integrated with the rest of the MHS. This limits DOD's ability to increase efficiency by maximizing the use of its direct care system of military treatment facilities (MTF), which USFHP enrollees are generally precluded from using because the USFHP's payment structure is intended to cover all enrollees' health care costs. The role of the USFHP has not been reassessed since TRICARE was implemented in the 1990s. However, DOD officials told us that there is not a function that the USFHP designated providers serve that the MCSCs could not perform. Furthermore, officials from all three MCSCs—which together serve over 4.5 million Prime enrollees—said that they would likely have the capacity and capability to provide TRICARE coverage to all current USFHP enrollees, if needed.

Because the USFHP's role of offering TRICARE Prime is duplicative of the role of the MCSCs, DOD has incurred added costs and inefficiencies. Although DOD would incur health care costs for the USFHP enrollees regardless of with whom they are enrolled, DOD pays administrative costs and profits to two different groups of contractors for providing the same TRICARE Prime benefit to the same population of eligible beneficiaries in many of the same areas. However, outside of the negotiated payment amounts, no one knows the designated providers' actual costs for administering the program since the USFHP contracts are characterized in statute as commercial item contracts. This means that the designated providers are exempt from sharing certified cost or pricing data with DOD, and they have been unwilling to share uncertified cost or pricing data when requested. As a result, DOD does not know how much of the approximately \$1.1 billion it pays the USFHP designated providers annually actually goes toward their administrative costs and profit versus the cost of health care services. DOD also incurs other expenses for the USFHP through support contracts, including a \$21 million data support contract, and through the management of various aspects of the program. Eliminating this statutorily required program would not only eliminate unnecessary costs and inefficiencies, but would also free up departmental resources that could be better used to manage other aspects of the TRICARE program.

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Abbreviations

DOD	Department of Defense
FAR	Federal Acquisition Regulation
MCSC	Managed Care Support Contractor
MHS	Military Health System
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act
USFHP	US Family Health Plan

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July 31, 2014

The Honorable Carl Levin
Chairman
The Honorable James Inhofe
Ranking Member
Committee on Armed Services
United States Senate

The Department of Defense (DOD) offered health care coverage to about 9.6 million eligible beneficiaries through TRICARE, its regionally structured health care program, at a cost of almost \$50 billion in fiscal year 2013.¹ TRICARE consists of a direct care system of military treatment facilities (MTF) and a purchased care system of civilian health care providers that is used to augment the direct care system when needed. For each TRICARE region in the United States, DOD's Defense Health Agency, which oversees the program, contracts with private sector companies—referred to as managed care support contractors (MCSC)—to administer TRICARE's benefit options, including TRICARE Prime, its managed care option.² Specifically, the MCSCs are responsible for developing and maintaining civilian provider networks and providing other services, such as enrollment, specialty care referrals, medical case management, claims processing, and customer service. Separately, in certain locations, TRICARE Prime is also offered by the US Family Health Plan (USFHP), an association of six health care providers—referred to as designated providers—located throughout the country. The USFHP is a statutorily required component of the Military Health System (MHS) that offers the TRICARE Prime option to about 134,000 active duty dependents and retirees and their dependents at a cost of over \$1 billion

¹TRICARE-eligible beneficiaries include active duty personnel and their dependents, medically eligible Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors.

²Prior to October 1, 2013, the TRICARE Management Activity, an entity within DOD, was responsible for overseeing the TRICARE program. In response to increasing pressure on its budgetary resources, DOD established the Defense Health Agency on October 1, 2013, to assume management responsibility of numerous functions of its medical health system, including the former TRICARE Management Activity, which was terminated on that date. For additional information, see GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability*, [GAO-14-49](#) (Washington, D.C.: Nov. 6, 2013).

in fiscal year 2013.³ The USFHP was initially incorporated into the MHS in 1982 when Congress enacted legislation transferring ownership of certain U.S. Public Health Service hospitals to the designated providers.⁴ This arrangement guaranteed the designated providers a stable revenue source by enabling them to provide care to military beneficiaries in addition to their private health care business, while also improving beneficiaries' access to care in the areas served by the designated providers. During the implementation of the TRICARE program in the 1990s, Congress required the designated providers to offer the TRICARE Prime benefit to their enrollees in accordance with the National Defense Authorization Act (NDAA) for Fiscal Year 1997.⁵ Today, the USFHP remains a health care option required by statute to be available to eligible beneficiaries in certain locations, despite TRICARE's national presence through the MCSCs.

As health care consumes an increasingly large portion of the overall Defense budget—the Congressional Budget Office reported in 2011 that DOD's health care costs are projected to reach nearly \$92 billion by 2030—it is important for DOD to operate its health care system efficiently, while also ensuring high-quality care.⁶ DOD leadership has also recently acknowledged the need to reduce duplication and overhead, operate its health system as efficiently as possible, and realize savings in the MHS.⁷ However, as the TRICARE program has matured and the cost of health care has increased, the USFHP has largely remained unchanged since the NDAA for Fiscal Year 1997, and its role has not been reassessed

³All beneficiaries who are eligible for DOD health care and who are under the age of 65, except active duty servicemembers, are eligible for USFHP enrollment. However, each year the number of USFHP enrollees may not exceed 110 percent of the previous year's enrollee population. See National Defense Authorization Act (NDAA) for Fiscal Year 1997, Pub. L. No. 104-201, § 724(b), 110 Stat. 2422, 2595 (1996) (codified at 10 U.S.C. § 1073 note). In this report, future citations to the NDAA for Fiscal Year 1997 will identify the applicable section of law without providing a full citation, as set forth here.

⁴The Military Construction Authorization Act, 1982 deemed these facilities to be facilities of the uniformed services, then known as Uniformed Services Treatment Facilities. See Pub. L. No. 97-99, § 911, 95 Stat. 1359, 1386 (1981).

⁵NDAA for Fiscal Year 1997, § 723(a).

⁶Congressional Budget Office, *Long-term Implications of the 2012 Future Years Defense Program*, Pub. No. 4281 (Washington, D.C.: June 2011). These numbers are reported in nominal dollars and have not been adjusted for inflation.

⁷See [GAO-14-49](#).

within the current MHS. Senate Report 112-173, which accompanied the Senate Committee on Armed Services' version of the NDAA for Fiscal Year 2013, mandated that GAO conduct a comprehensive review of DOD's health care contracts, and identify opportunities for potential savings and efficiencies.⁸ In this report, we examine (1) the role of the USFHP within the MHS, and (2) the extent to which the USFHP affects DOD's health care costs.

To examine the role of the USFHP within the MHS, we reviewed requirements relevant to the USFHP and the TRICARE program, including those established in federal laws and regulations, contracts, policy manuals, and benefit handbooks.⁹ We interviewed DOD officials, including officials from DOD's Defense Health Agency; officials at each of the TRICARE Regional Offices (North, South, and West); Army, Navy, and Air Force regional officials; and officials at MTFs located within USFHP service areas to discuss the role of the USFHP and its impact on the regional TRICARE program, including DOD's direct care system. We also reviewed DOD's reports on its TRICARE program. In addition, we interviewed officials from the six USFHP designated providers, the USFHP Alliance, and the three regional MCSCs, and obtained and analyzed information about their operations, including information about their TRICARE Prime benefits, enrollees, geographic service areas, and provider networks.¹⁰ We reviewed and applied GAO's framework for addressing fragmentation, overlap, and duplication to assess the extent to which the USFHP and TRICARE MCSCs engaged in the same activities or strategies to provide the same services to the same target recipients or individuals.¹¹ We also interviewed officials from beneficiary interest

⁸S. Rep. No. 112-173, at 131-132 (2012). For our work on TRICARE pharmacy service contracts, see GAO, *Defense Health Care: Evaluation of TRICARE Pharmacy Services Contract Structure Is Warranted*, [GAO-13-808](#) (Washington, D.C.: September 2013). For our work on TRICARE managed care support contracts, see GAO, *Defense Health Care: Acquisition Process for TRICARE's Third Generation of Managed Care Support Contracts*, [GAO-14-195](#) (Washington, D.C.: March 2014). For our work on TRICARE dental services contracts, see GAO, *Defense Health Care: TRICARE Dental Services Contracts' Requirements and Structure*, [GAO-14-497](#) (Washington, D.C.: June 2014).

⁹We did not assess the department's compliance with the program's requirements.

¹⁰The USFHP Alliance is the association that represents the interests of the six designated providers in interactions with DOD and Congress.

¹¹See GAO, *2014 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, [GAO-14-343SP](#) (Washington, D.C.: April 8, 2014).

groups to obtain their perspective about the USFHP. We did not assess the quality of the care or benefits offered by either the USFHP designated providers or the MCSCs.

To examine the extent to which the USFHP affects DOD's health care costs, we obtained and reviewed USFHP cost information, including the costs of the designated provider contracts and other DOD contracts related to the administration of the program. To better understand the requirements related to the USFHP's costs, we reviewed relevant federal laws and regulations, including laws pertaining to the USFHP and the Federal Acquisition Regulation (FAR).¹² We interviewed DOD officials and officials from DOD's actuarial contractor to obtain information about the costs of the USFHP and how these costs have changed over time. Additionally, we asked DOD's contractor to provide us with a breakdown of the average capitation payments paid to the designated providers for fiscal year 2013, which includes amounts that have been allocated to cover the costs of health care services for USFHP enrollees, as well as the administrative costs and profit margins for the designated providers.¹³ Additionally, we obtained information from DOD officials and its actuarial contractor about DOD's annual process for developing its capitation payment rates for the designated providers, the components of these payments, and challenges related to determining how much these payment rates reflect actual health care costs. We obtained information from DOD's contractor about the reliability of the data on the capitation payment rates, and we determined that these data were sufficiently reliable for the purposes of our report. Finally, we obtained information about the USFHP acquisition process and DOD's annual process for negotiating the designated provider capitation payments to identify resources related to these efforts.

We conducted this performance audit from March 2013 to July 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

¹²The FAR defines uniform policies for the acquisition of supplies and services across the federal government. The FAR is codified in title 48 of the Code of Federal Regulations.

¹³Under capitation payments, health care plans are prospectively paid a fixed monthly rate per enrollee to provide or arrange for most health care services.

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Overview of the USFHP

The USFHP is a statutorily required component of the MHS that offers the TRICARE Prime option to eligible military beneficiaries through 6 designated providers in certain locations across the country.¹⁴ Over the years, the number of designated providers has dropped from 10 to 6. The 6 USFHP designated providers that currently administer the USFHP are: (1) Johns Hopkins Medical Services Co., (2) Brighton Marine Health Center, (3) Martin's Point Health Care, (4) CHRISTUS Health, (5) Pacific Medical Centers, and (6) St. Vincents Catholic Medical Centers. (See appendix I for a comparison of USFHP designated providers in 1994 and 2014.) The reduction in designated providers has largely been due to provider consolidations.¹⁵ In one case, a designated provider opted to no longer participate in the program.¹⁶ According to DOD officials, USFHP enrollees for that designated provider were successfully transitioned to other health care programs for which they were eligible, including the TRICARE options administered by the TRICARE MCSC in that region.

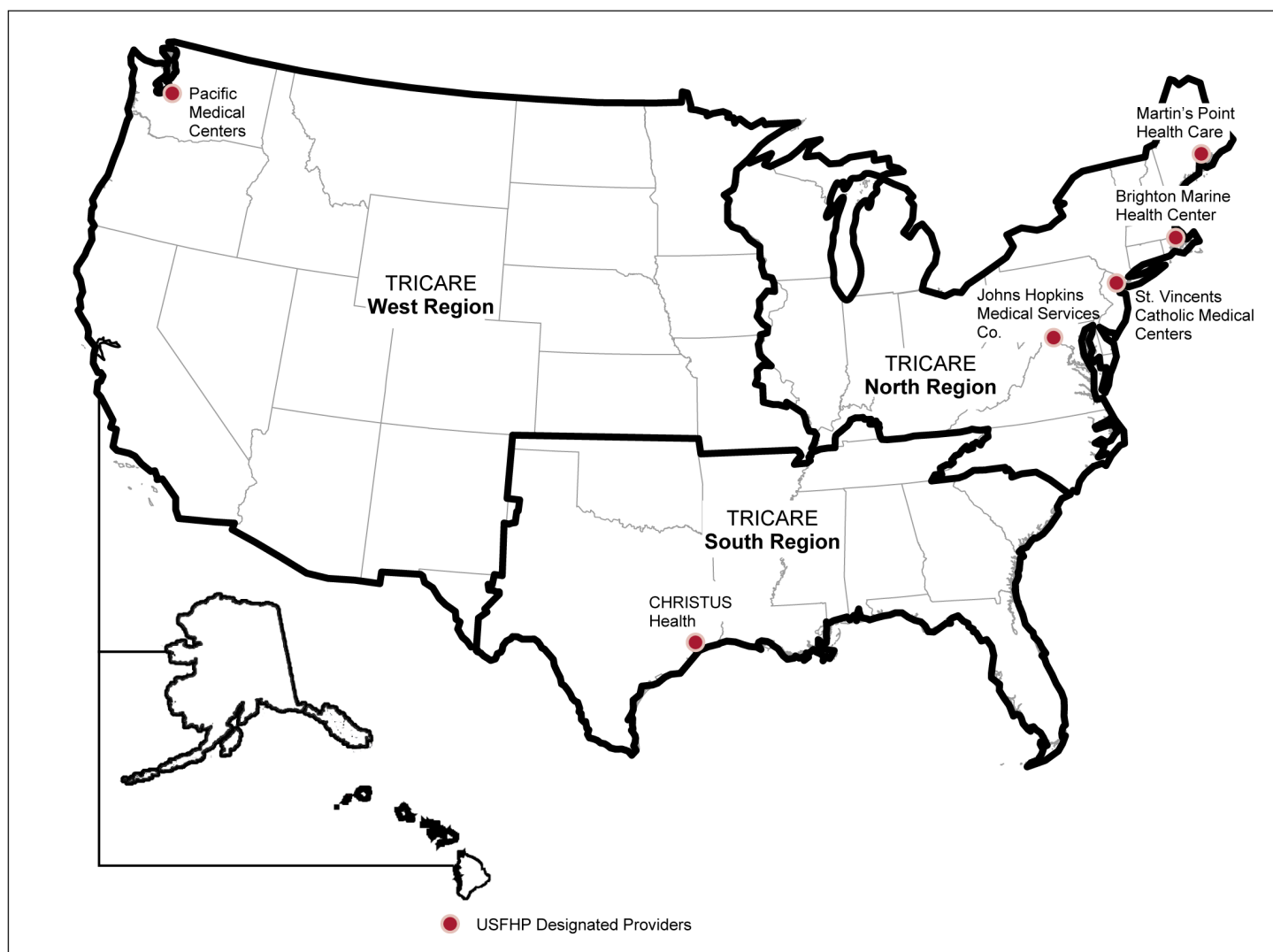
Some of the designated providers provide care exclusively to beneficiaries enrolled in the USFHP, while others also provide health care services to beneficiaries of other health plans and may have additional lines of business. (See appendix II for more information on the characteristics of each of the designated providers.) Each of the designated providers—and their respective service areas—are located within one of the three TRICARE regions in the United States. Figure 1 below illustrates the location of the USFHP designated providers relative to the locations of the three TRICARE regions.

¹⁴See NDAA for Fiscal Year 1997, §§ 721-727.

¹⁵Specifically over the years, some hospitals that were formerly separate designated providers were consolidated under CHRISTUS Health.

¹⁶One former designated provider, Lutheran Medical Center, merged with Fairview Hospital in 1995 and in 1997 became part of the Cleveland Clinic Health System. DOD officials told us that this designated provider decided to end its USFHP contract with the department in 2007.

Figure 1: Location of Six US Family Health Plan (USFHP) Designated Providers within the Three TRICARE Regions



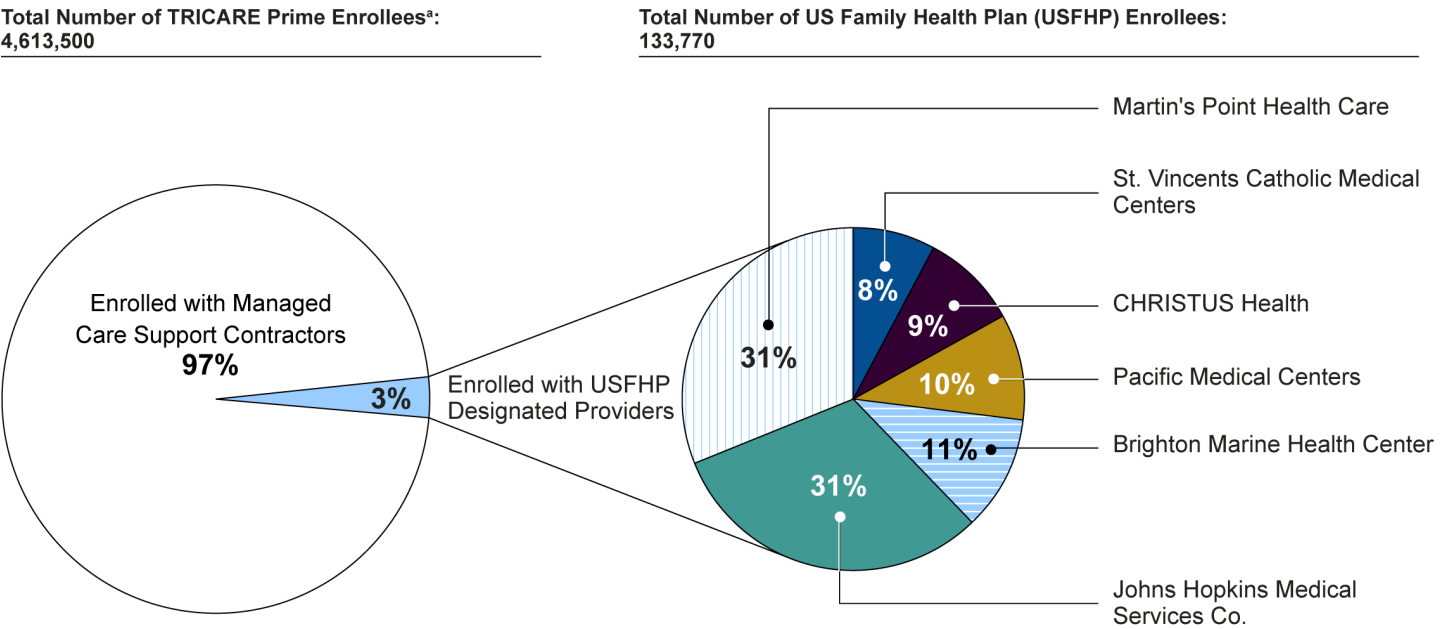
Source: GAO analysis of data from the Department of Defense; Map Resources (map). | GAO-14-684

Note: TRICARE is organized in three regions across the United States—North, South, and West. Within these regions, the Department of Defense contracts with managed care support contractors to develop provider networks and to administer TRICARE's benefit options. Alaska and Hawaii are located in TRICARE's West region.

The six designated providers offer TRICARE Prime to eligible beneficiaries through civilian provider networks in their service areas. To receive care through the USFHP, eligible beneficiaries must enroll in the program. All beneficiaries eligible for DOD health care and who are under the age of 65, except active duty servicemembers, are eligible for USFHP

enrollment.¹⁷ Beneficiaries who live in a location served by one of the six designated providers may elect to enroll in TRICARE Prime with the USFHP instead of enrolling with the MCSC. As of October 2013, approximately 134,000 beneficiaries were enrolled in the USFHP—about 3 percent of all TRICARE Prime enrollees. See figure 2 for the total number of USFHP enrollees as a percent of total TRICARE Prime enrollees, as also delineated by designated provider.

Figure 2: US Family Health Plan (USFHP) Enrollees as a Percent of Total TRICARE Prime Enrollees, and by Designated Provider as of October 2013



Source: GAO analysis of Managed Care Support Contractor and USFHP Designated Provider data. | GAO-14-684

^aTRICARE Prime includes enrollees in Prime (military and civilian primary care managers), TRICARE Prime Remote, TRICARE Young Adult Prime, and US Family Health Plan; and excludes beneficiaries in TRICARE For Life, TRICARE Plus, TRICARE Young Adult Standard, and TRICARE Reserve

¹⁷Previously, all Medicare-eligible individuals aged 65 and older were also allowed to enroll in the USFHP. The NDAA for Fiscal Year 2012 amended the law, requiring beneficiaries enrolling in USFHP after September 30, 2012 to discontinue their USFHP coverage and transition to TRICARE For Life once they reach 65 years of age. Beneficiaries enrolled with a USFHP designated provider on September 30, 2012 did not have to discontinue their USFHP coverage after reaching 65 years of age. Pub. L. No. 112-81, § 708, 125 Stat. 1298, 1474 (2011), amending section 724(e) of the NDAA for Fiscal Year 1997.

Select. The total number of TRICARE Prime enrollees excludes Prime enrollees located outside of the United States.

The NDAA for Fiscal Year 1997 mandated a number of key aspects of the USFHP. For example, the statute prohibits DOD from reducing the size of a designated provider's geographic service area below the size in effect as of September 30, 1996.¹⁸ However, DOD does have discretion to increase the size of a designated provider's service area. In addition, DOD is required to enter into sole-source contracts with the designated providers to administer the USFHP.¹⁹ The statute also requires these contracts to be treated as commercial item contracts under the FAR—a designation that prohibits DOD from requiring the designated providers to provide certified cost or pricing data during contract negotiations.²⁰ Additionally, the statute mandates that annual payments to the designated providers are to be made on a full-risk capitation payment basis,²¹ which means that the designated providers are fully at-risk for the cost of beneficiaries' health care services. These payments cover the projected costs of all the medical care an enrollee needs for the year plus administrative costs and profit. DOD and each of the designated providers annually negotiate the amounts of their capitation payments, which represent projected costs based on estimates and adjustments for factors such as differences in health care costs by geographic area and enrollees' health status.²² The statute limits total capitation payments to the designated providers, which cannot exceed the cost that would have been incurred by the government if USFHP enrollees had received their care through Medicare or TRICARE, including its direct care system of

¹⁸NDAA for Fiscal Year 1997, § 722(e).

¹⁹NDAA for Fiscal Year 1997, § 722(b)(2).

²⁰See NDAA for Fiscal Year 1997, § 722(b)(2). Offerors competing for commercial item contracts may not be required to provide certified cost or pricing data during contract negotiations. FAR § 15.403-1(b)(3). Section 2.101 of the FAR defines cost or pricing data as all facts that buyers and sellers would reasonably expect to affect price negotiations. In acquisitions where certified cost or pricing data are required, section 15.406-2 of the FAR provides that contractors must certify that required cost or pricing data are accurate, complete, and current as of a specified date.

²¹NDAA for Fiscal Year 1997, § 726(a).

²²The final rates are the results of negotiations involving two rates: (1) rates that are proposed by the designated providers, and (2) rates that are proposed by DOD.

Overview of TRICARE

MTFs or its purchased care system of civilian providers.²³ The USFHP contracts are expected to cost approximately \$6.4 billion over 5 years.

In 1993, DOD reformed the MHS by implementing TRICARE, a nationwide managed health care program designed to improve access and ensure high-quality health care while also addressing DOD's rising health care costs. TRICARE consists of a direct care system of MTFs and a purchased care system of civilian health care providers that are used to augment the direct care system when needed. TRICARE offers three basic benefits to eligible beneficiaries: TRICARE Prime (a managed care option), TRICARE Extra (a preferred provider option), and TRICARE Standard (a fee-for-service option). In addition, DOD administers other TRICARE benefits, such as TRICARE For Life, which is secondary coverage to Medicare for all beneficiaries who have both Medicare Parts A and B.

DOD's Defense Health Agency uses MCSCs to administer TRICARE's benefit options in three regions across the United States—North, South, and West. Within these regions, MCSCs are required to develop provider networks and offer the TRICARE Prime option in geographic areas called Prime Service Areas.²⁴ DOD requires MCSCs to establish Prime Service Areas around MTFs and Base Realignment and Closure sites to augment the capability and capacity of MTFs with a civilian provider network.²⁵ Beneficiaries living in Prime Service Areas can choose between the TRICARE Prime, TRICARE Standard, and TRICARE Extra options.²⁶ Beneficiaries who choose TRICARE Prime—the managed care option—must enroll. The MCSCs are responsible for assigning Prime enrollees to Primary Care Managers, who provide or arrange for all health care

²³NDA for Fiscal Year 1997, § 726(b).

²⁴Prime Service Areas have been established in zip codes that are within a 40 mile radius of an MTF or Base Realignment and Closure site. As of October 1, 2013, DOD eliminated the additional Prime Service Areas that were not near MTFs or Base Realignment and Closure sites in an effort to reduce health care costs. This change affected approximately 181,600 beneficiaries previously eligible for the TRICARE Prime option.

²⁵Base Realignment and Closure sites are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

²⁶TRICARE also offers several other plans, including TRICARE Young Adult-Standard Option (for beneficiaries' dependents up to age 26) and TRICARE Reserve Select (for certain National Guard and Reserve servicemembers).

services required by their enrollees. Beneficiaries who live outside of Prime Service Areas can choose between the TRICARE Standard and TRICARE Extra options.

Unlike the USFHP contracts, the TRICARE managed care support contracts are awarded on a competitive basis. Further, DOD reimburses the MCSCs for the cost of health care services provided to TRICARE beneficiaries. As a result, the MCSCs are not “at risk” for their beneficiaries’ health care costs as are the designated providers under USFHP. As of fiscal year 2012, the TRICARE managed care support contracts comprised DOD’s three largest purchased care contracts. The costs of these three contracts are expected to total approximately \$56 billion over their 5-year performance period.

The USFHP Duplicates the Role of the MCSCs in offering the TRICARE Prime Option and is not Integrated with the Rest of the MHS

The USFHP’s role within the current MHS is duplicative because it offers military beneficiaries the same TRICARE Prime benefit that is offered by the MCSCs across much of the same geographic service areas and through many of the same providers. Furthermore, the USFHP is not integrated with the rest of the MHS, and does not support DOD’s efforts to increase efficiency because it potentially diverts enrollees away from DOD’s direct care system.

The USFHP’s Role within the MHS is Duplicative

The USFHP’s role in offering TRICARE Prime within the context of the current MHS duplicates the role of the MCSCs in several important ways.²⁷ For example, the USFHP designated providers and the MCSCs both offer the same TRICARE Prime benefit as required by law.²⁸ DOD implements this uniform benefit requirement by incorporating the

²⁷We have previously defined duplication as a situation where two or more programs are engaged in the same activities or strategies to meet a need, or provide the same services to the same target recipients or individuals. See [GAO-14-343SP](#).

²⁸Specifically, section 723(a) of the NDAA for Fiscal Year 1997 requires designated providers to offer enrollees the health benefit option prescribed by section 731 of the NDAA for Fiscal Year 1994. This refers to the TRICARE Prime benefit option applicable to MCSCs, which is to be as uniform as possible throughout the United States. Both provisions are codified, as amended, at 10 U.S.C. § 1073 note.

TRICARE Policy Manual, which includes requirements for administering the TRICARE Prime option, into its contracts with both the USFHP designated providers and the TRICARE MCSCs.²⁹ As a result, beneficiaries enrolled in TRICARE Prime through either the designated providers or the MCSCs receive the same benefit and have the same cost sharing responsibilities.

There is also significant overlap in the geographic service areas in which the USFHP designated providers and the MCSCs offer TRICARE Prime. As of October 1, 2013, four of the six USFHP designated providers had more than 80 percent of their service area zip codes overlapping with the MCSCs' Prime Service Areas.³⁰ See table 1 for the percent of USFHP zip codes included in areas where the MCSCs also offer TRICARE Prime.

Table 1: Percent of US Family Health Plan (USFHP) Service Area Zip Codes That Overlap with the TRICARE Managed Care Support Contractors' (MCSC) Prime Service Area Zip Codes

TRICARE Region	TRICARE MCSC	USFHP Designated Provider	Percent of Zip Codes that Overlap ^a
North	Health Net Federal Services	Johns Hopkins Medical Services Co.	90%
		St. Vincents Catholic Medical Centers	84%
		Brighton Marine Health Center	82%
		Martin's Point Health Care	41%
South	Humana Military Healthcare Services	CHRISTUS Health	57%
West	UnitedHealth	Pacific Medical Centers	88%

Source: GAO analysis of Department of Defense data. | GAO-14-684

Note: TRICARE is organized in three regions across the United States—North, South, and West. Within these regions, the Department of Defense contracts with managed care support contractors to develop provider networks and to administer TRICARE's benefit options.

^aBased on zip code information as of October 2013.

The significant service area overlap means that USFHP enrollees predominantly live in areas where MCSCs also offer TRICARE Prime. In general, because all of the beneficiaries who are eligible for the USFHP are also eligible for TRICARE Prime offered by the MCSCs, USFHP enrollees in these areas would likely be able to maintain their TRICARE

²⁹Operating guidelines and instructions for the MCSCs and the designated providers are included in several TRICARE manuals, including the TRICARE Policy Manual.

³⁰Enrollees in the USFHP must live in specific zip codes that are near one of the six designated providers.

Prime benefits through the MCSC if the USFHP did not exist.³¹ The two designated providers with a lower degree of overlap—CHRISTUS Health and Martin’s Point Health Care—are located in areas that have fewer or no MTFs or Base Realignment and Closure sites. Therefore, while USFHP enrollees in these two specific areas would not have the same level of access to TRICARE Prime through the MCSCs, they could still use other TRICARE options that are available nationwide through the MCSCs such as TRICARE Standard, or other programs for which they may be eligible. The MCSCs currently serve over 4.5 million Prime enrollees—therefore, adding 134,000 USFHP enrollees would not appear to be a significant burden, according to MCSC officials. All three MCSCs told us that they would likely have the capacity and capability to provide TRICARE coverage to all of the current USFHP enrollees, including the TRICARE Prime option or other options, as appropriate, depending on the enrollees’ locations. Specifically, if the USFHP did not exist, two of the three MCSCs could each be responsible for fewer than 6,000 additional enrollees, and the third MCSC would potentially be responsible for approximately 79,000 enrollees, if all affected beneficiaries maintained their TRICARE coverage. However, some affected beneficiaries might choose to enroll in other health care programs for which they may be eligible.

We also identified significant overlap in the provider networks of the USFHP designated providers and the MCSCs.³² Specifically, our analyses showed that several of the designated providers had a 40 to 50 percent overlap with the MCSC networks while the remaining designated providers had network overlap ranging from 20 to 37 percent. (See table 2.) Consequently, depending on the location, USFHP enrollees may be able to use the same providers under the MCSCs’ provider networks if the USFHP did not exist. The designated providers differ in their preferences as to whether their providers also participate in the MCSCs’ networks. For example, officials from one designated provider told us that they strive to support the entire MHS, and therefore

³¹The MCSCs are responsible for providing health care services to beneficiaries under 65 years of age. Once these beneficiaries reach 65 and are Medicare eligible, they must transition to TRICARE For Life. If the USFHP did not exist, current USFHP enrollees who are Medicare eligible would likely be transitioned to TRICARE For Life.

³²We limited our analysis to include only providers with a Doctor of Medicine or Doctor of Osteopathic Medicine degree. The inclusion of other types of providers, including nurse practitioners or physician’s assistants, could potentially affect the degree of overlap.

encourage all of their providers to participate in both the USFHP and MCSC networks, while officials from another told us that they encourage their providers not to participate with the MCSC’s network.³³ In general, providers are allowed to contract with any organization they choose; therefore, those currently serving only the USFHP might also choose to participate in the applicable MCSC’s network.

Table 2: Percent of US Family Health Plan (USFHP) Providers Also Participating in Managed Care Support Contractors’ (MCSC) Provider Networks

TRICARE Region	MCSC	USFHP Designated Provider	Percent of USFHP Providers in Both Networks ^a
North	Health Net Federal Services	Johns Hopkins Medical Services Co.	40%
		St. Vincents Catholic Medical Centers	47%
		Brighton Marine Health Center	20%
		Martin’s Point Health Care	27%
South	Humana Military Healthcare Services	CHRISTUS Health	35%
West	UnitedHealth	Pacific Medical Centers	51%

Source: GAO analysis of Managed Care Support Contractor and USFHP designated provider data. | GAO-14-684

Note: TRICARE is organized in three regions across the United States—North, South, and West. Within these regions, the Department of Defense contracts with managed care support contractors to develop provider networks and to administer TRICARE’s benefit options.
^aBased on provider network information as of October 1, 2013.

The duplication and related overlap between the USFHP and the MCSCs’ TRICARE Prime option has been longstanding in part because the program’s role has not been reassessed since TRICARE was implemented in the 1990s. Many key features of the USFHP have remained in place since the enactment of the NDAA for Fiscal Year 1997, notwithstanding TRICARE’s growth during the intervening years. DOD officials told us that there is not a function that the USFHP designated providers serve that the MCSCs could not perform. However, because the USFHP is statutorily required, DOD does not have the authority to eliminate it and transition the USFHP enrollees into the regional TRICARE program managed by the MCSCs or into other programs for which they may be eligible.

³³Neither the USFHP designated providers’ officials nor the MCSCs’ officials could tell us the extent to which their providers contracted with other plans because this is considered proprietary information.

The USFHP Limits DOD's Ability to Maximize Use of Its Direct Care System Because it Operates Independently of the Integrated MHS

One of the goals of the MHS is to maximize use of the direct care system's MTFs, a goal most recently articulated in DOD's budget request for fiscal year 2015.³⁴ TRICARE's managed care support contracts are designed to support this goal by requiring the MCSCs to optimize the use of the direct care system as part of an integrated MHS. For example, MCSCs are to first assign Prime enrollees to a Primary Care Manager located at an MTF until its enrollment capacity has been reached, at which point, enrollees are assigned to a Primary Care Manager from the civilian provider network.³⁵ MCSCs are also required to give their region's MTFs the right of first refusal for all specialty care referrals for Prime enrollees to ensure that, if it has the capability and capacity to administer the care, the MTF has the opportunity to do so prior to referring them to the civilian network. In these ways, the MCSCs help promote the efficient use of DOD's direct care system by helping the MTFs operate at full capacity.

DOD is unable to promote the efficient use of DOD's direct care system through the USFHP, which operates independently of the integrated MHS as a distinct statutory program. Unlike Prime beneficiaries enrolled with the MCSCs, USFHP enrollees are generally precluded from receiving care at MTFs due to the program's fixed-price capitation payment structure that is intended to cover all enrollees' health care costs. Given the extent of overlap with the MCSCs' Prime Service Areas, which are generally around MTFs, thousands of USFHP enrollees are precluded from using the direct care system. To limit any additional future impact of the USFHP on MTFs, DOD has denied designated providers' requests for service area expansions.³⁶ For example, in 2012, a designated provider submitted a request to DOD to expand its existing service area to a location that also included several MTFs. However, DOD denied this request, citing duplication with the existing MCSC network and a potentially higher health care cost per beneficiary to provide care through the USFHP since its enrollees would not be able to use the local MTFs.

³⁴Department of Defense, *United States Department of Defense Fiscal Year 2015 Budget Request: Overview* (March 2014).

³⁵MTF commanders have the authority and responsibility to set priorities for enrollment to MTF Primary Care Managers in order to maximize the use of their facilities.

³⁶DOD is statutorily prohibited from reducing designated providers' geographic service areas, but it does have the authority to approve or deny requests for expansion.

As an exception, a USFHP enrollee may access an MTF for emergency services, and the designated provider is then contractually responsible for reimbursing the MTF for that care. In addition, USFHP designated providers may negotiate Memorandums of Agreement with the MTFs for the purpose of referring enrollees to them on the condition that the designated providers would be responsible to the MTFs for the associated health care costs of any referred beneficiaries. During the course of our review, however, we found that no Memorandums of Agreement had been established for this purpose, although one designated provider told us that it was in the process of negotiating one.

The USFHP Has a Competitive Advantage over the MCSCs, Potentially Diverting Enrollees Away from the Direct Care System

Certain features of the USFHP give designated providers a competitive advantage over the MCSCs—one that likely results in increased costs instead of the lower costs that typically result from competition. For example, the USFHP designated providers offer certain discounts and services that go beyond TRICARE's uniform benefits, such as dental and vision care discounts. (See appendix III for a description of these discounts and services.) DOD officials acknowledged that the MCSCs' Prime enrollees do not receive these discounts and services because MCSCs are paid on a cost reimbursement basis only for allowable TRICARE Prime benefits. DOD officials acknowledged that these discounts and services may not be entirely consistent with TRICARE's uniform benefit requirement, but they have not taken issue with this practice because the USFHP designated providers receive a fixed-capitation payment, and therefore, DOD is not billed separately for any discounts and services that the designated providers choose to offer.³⁷ Although the USFHP designated providers do not bill DOD for these discounts and services, it is not known how the designated providers account for these discounts and services in developing their proposed capitation payments. The USFHP designated providers promote these discounts and services in their marketing materials, which may lead to beneficiaries choosing to enroll with the USFHP designated providers over the MCSCs in areas where both programs are offered.³⁸

³⁷In contrast, the MCSCs are paid on a cost reimbursement basis for allowable benefits.

³⁸DOD officials do not know the extent to which these additional discounts and services divert enrollees from the MCSCs and, thus, the direct care system.

MTF officials expressed concern that the USFHP diverts beneficiaries away from the MCSCs and, correspondingly, from the direct care system. MTFs rely on beneficiaries as a source of education and training opportunities. MTF officials we spoke with expressed concerns that the USFHP program detracts from the volume and complexity of cases needed to maintain a robust graduate medical education and skills training program. For example, a military service medical official noted that medical facilities with Magnetic Resonance Imaging capabilities seek to maximize the use of this equipment and strive to offer their providers opportunities for related specialty care training while treating enrollees needing this type of service. However, if the MTF is located near a USFHP, this official noted that such training opportunities may be more limited because any USFHP enrollees who need these services would not obtain them from their local MTF.

In addition, since the USFHP contracts are full-risk capitated arrangements, the designated providers are not limited to the TRICARE provider reimbursement rates, and thus have the flexibility to offer their providers higher rates or other incentives. In contrast, MCSCs' network providers must accept TRICARE maximum allowable charges as payment in full, and these rates are generally based on Medicare rates.³⁹ The increased flexibility in setting reimbursement rates may provide the USFHP designated providers a competitive advantage over the MCSCs in recruiting providers to their networks. The USFHP designated providers told us that they exceed the TRICARE provider reimbursement rates on occasion, depending on their market areas, although some generally use the TRICARE rates as guidelines. DOD officials told us of an example where the USFHP designated provider recruited a primary care provider group, which resulted in the group leaving the MCSC network, and these officials were concerned that reimbursement rates may have been a factor in this decision. Consequently, beneficiaries who want to obtain care from this provider group may choose to enroll with the USFHP instead of enrolling with the MCSC. By maintaining exclusive relationships with providers—especially those that are highly desired by beneficiaries—this designated provider has a competitive advantage over the MCSC, potentially drawing beneficiaries away from and limiting the use of the direct care system.

³⁹By law, TRICARE reimbursement rates for civilian providers are generally limited to Medicare rates, but network providers may agree to accept lower reimbursement rates as a condition of network membership.

The provision of additional discounts and services to USFHP enrollees or exclusive provider arrangements may contribute to the USFHP's high satisfaction rates, which the designated providers point to as a measure of the program's success. While high satisfaction rates may be viewed as an argument in favor of maintaining the USHFP as a separate program, doing so comes at the expense of an integrated MHS that optimizes the use of MTFs.

The USFHP's Duplicative Role Results in Added Costs and Inefficiencies for DOD

Because the USFHP's role of offering TRICARE Prime is duplicative of the role played by the MCSCs, DOD has incurred added costs by paying the designated providers to simultaneously administer the same benefit as the MCSCs. Consequently, due to its duplicative role, managing the USFHP is also an inefficient use of DOD's resources.

DOD Incurs Added Costs by Paying the Designated Providers to Simultaneously Administer the Same Benefit as the MCSCs

Because the USFHP is a statutorily required component of the MHS, DOD must pay the USFHP designated providers to administer the same benefit to the same population of eligible beneficiaries in many of the same locations as the MCSCs. Although DOD would incur health care costs for the USFHP enrollees regardless of with whom they are enrolled, DOD must also pay administrative costs and profits to two different groups of contractors for providing the same TRICARE Prime benefit. Currently, administrative costs and profit margins are part of the negotiated payments for the USFHP contracts. We obtained a breakdown of the average capitation payments DOD made to the designated providers for USFHP enrollees for fiscal year 2013, and we estimated that the administrative costs and profit margins were approximately \$27 million of the total cost of the program for that year (2.4 percent of \$1.1 billion).⁴⁰ However, our estimate may not represent the total administrative costs and profit realized since DOD's knowledge of the actual cost components underlying these negotiated payments is

⁴⁰The average capitation payments were based on average amounts paid for USFHP enrollees over and under 65 years of age, and were broken out by portions that would cover the cost of health care services for USFHP enrollees, as well as the designated providers' administrative costs and profits margins.

limited.⁴¹ Although the designated providers are exempt from any requirement to share certified cost or pricing data, DOD has requested that they share uncertified cost or pricing data. However, according to DOD officials, the designated providers have been unwilling to do so when asked. Thus, DOD does not know how much of the approximately \$1.1 billion it pays the USFHP designated providers annually goes toward their actual administrative costs and profit versus the cost of health care services for USFHP enrollees. Furthermore, it is also unknown how the actual administrative costs and profit of the designated providers compare to the MCSCs.

In 2010, DOD hired a consultant to review its methodology for setting capitation rates for the designated providers. Overall, the consultant found that DOD's process for establishing capitation rates was actuarially sound and that the rates were generally being set in accordance with current legislation. Nonetheless, the consultant did report some concerns with the rates—and thus, the cost-effectiveness of the USFHP—since the rates may not reflect the designated providers' actual costs of delivering health care. More specifically, the consultant stated that the health care costs used by the designated providers in negotiating the capitation payment rates do not accurately represent their true cost of providing benefits under the program and offered several recommendations to improve the cost-effectiveness of the capitation rate setting process. Additionally, we found that the program likely provides a significant source of income for the designated providers as more than half of them rely heavily on the USFHP for their business. Specifically, USFHP enrollees comprise 100 percent of the total beneficiaries enrolled in two of the six designated providers and more than 60 percent for two others.⁴²

⁴¹See NDAA for Fiscal Year 1997, § 722(b)(2). The FAR exempts commercial item contracts from the requirement to provide certified cost or pricing data during contract negotiations.

⁴²One of the two designated providers whose beneficiary populations are entirely comprised of USFHP enrollees also has another line of business; specifically, the designated provider told us it also operates a medical malpractice insurance business. For the remaining two designated providers, USFHP enrollees comprise 14 and 15 percent of their total beneficiary populations. These two designated providers told us they are subsidiaries of larger corporations, and their total beneficiary populations include beneficiaries enrolled with the USFHP and beneficiaries enrolled in other health care programs through the larger corporations.

The costs associated with the USFHP designated provider contracts are not the only costs DOD incurs for this program. DOD also has a data support contract that provides information technology support services to the USFHP designated providers.⁴³ DOD officials told us that this contract, which is expected to cost \$21 million over 5 years, exclusively supports the USFHP designated providers and that there is no comparable contract in place for the MCSCs. Additionally, a portion of DOD's TRICARE Help Desk contract supports the USFHP at a cost of about \$272,000 per year, according to DOD officials.⁴⁴ If the USFHP did not exist, DOD would potentially save millions of dollars from duplicative administrative costs and profits.⁴⁵

Managing the USFHP is an Inefficient Use of DOD's Resources

In addition to the costs associated with the USFHP designated providers' capitation payments and support contracts, DOD must expend resources managing various aspects of the USFHP. As we have previously reported, expending resources on unnecessarily duplicative programs is inherently inefficient and that in most of these situations, there are opportunities for greater efficiencies or effectiveness by eliminating unnecessary duplication.⁴⁶ For example, DOD officials told us that several officials are responsible for the overall management of the USFHP, which includes modifying the contracts and educating designated providers'

⁴³The data support contractor is responsible for collecting data submitted by the designated providers and interfacing them with DOD's Defense Enrollment and Eligibility Reporting System for the purpose of collecting enrollment and eligibility data as well as sharing USFHP enrollee demographics with DOD, among other things.

⁴⁴DOD officials told us that this contract primarily provides administrative and management assistance for the Defense Health Agency's TRICARE Health Plan Directorate senior leadership. Additionally, this contract also supports one of TRICARE's dental programs.

⁴⁵It is possible that if the USFHP enrollees were transitioned to the MCSCs, DOD could experience some upfront costs with doing so; for example, the department may have to pay the MCSCs additional money to cover some costs associated with absorbing new enrollees into their networks. However, it is also possible that the MCSCs' nationwide presence, the economies of scale related to their large beneficiary populations, and the competitive award process related to their contracts could reduce any costs associated with transferring enrollees from the smaller USFHP contracts to these larger contracts.

⁴⁶See [GAO-14-343SP](#).

staff about program requirements.⁴⁷ Additionally, several DOD officials are responsible for conducting the acquisition process necessary to enter into contracts with the USFHP designated providers, which involves acquisition planning, the development of a request for proposals, and the evaluation of proposals. DOD officials said that the most recent process lasted approximately 9 months, and as a result, they extended the length of the USFHP contracts to 10 years in an effort to reduce the administrative burden associated with it.⁴⁸

DOD is also required to annually negotiate capitation payment amounts with each of the six USFHP designated providers.⁴⁹ DOD officials told us that the process for negotiating these payments lasts approximately 8 months and includes several steps, such as collecting data from different sources, developing proposed payments, and negotiating the final payment amount. There are several participants in these negotiations from both sides, including a contractor that provides DOD with actuarial assistance.⁵⁰ These annual payment negotiations are not necessary for the managed care support contracts, which are structured differently. Eliminating the USFHP would allow DOD to potentially realize savings, as well as better focus its resources on managing other aspects of the TRICARE program.

⁴⁷DOD officials told us contract modifications can occur due to reasons such as changes to the TRICARE manuals. The TRICARE manuals provide instruction, guidance, and responsibilities in addition to the requirements set forth in the designated providers' contracts or in the incorporated federal statutes and regulations. These manuals are incorporated by reference into the USFHP contracts, and abiding by them is part of the designated providers' contractual requirements.

⁴⁸The last iteration of USFHP contracts was for one base year and four option years, for a total duration of 5 years. The current contracts have been awarded to include one base year plus nine option years, for a total duration of 10 years. These contracts went into effect October 1, 2013.

⁴⁹NDAA for Fiscal Year 1997, § 726(c).

⁵⁰This contractor currently supports DOD's TRICARE contracts by providing services such as (1) budgeting, pricing, and financial analyst support; (2) policy support; (3) contract cost adjustment; and (4) reimbursement support.

Conclusions

The USFHP's role in providing care to eligible military beneficiaries became duplicative once the nationwide TRICARE program was implemented in the 1990s. Since the NDAA for Fiscal Year 1997 required the USFHP to offer TRICARE Prime, there has been no assessment of the continued relevancy of this program despite the apparent overlap and duplication with the MCSCs, which has likely resulted in added costs and inefficiencies for DOD. Compounding this problem is the fact that the USFHP operates at odds, often in competition, with the rest of the MHS, which limits DOD's effort's to maximize the use of its direct care system of military hospitals and clinics. Moreover, it is not known how much it costs to deliver health care under the program, or the extent of administrative costs and profits that accrue to designated providers, because the designated providers have not been required to, nor have they chosen to, share cost or pricing data with DOD.

The existence of a duplicative program that provides the same benefit to the same group of beneficiaries within many of the same service areas runs counter to DOD's current environment of budget constraints and the department's need to control rising health care costs. Eliminating this statutorily required program would not only eliminate unnecessary costs and inefficiencies but would also free up departmental resources that could be better used to manage and oversee the TRICARE program. However, it will be important to transition the 134,000 USFHP enrollees to other health care programs prior to eliminating the program to ensure the continuity of their care. According to DOD and MCSC officials, the MCSCs already have the national coverage, capability, and capacity to absorb these enrollees, assuming they do not obtain coverage elsewhere. Given the extent to which the USFHP's role in offering TRICARE Prime duplicates and overlaps with the MCSCs, there is no compelling reason to maintain the USFHP as part of the MHS and incur the added costs and inefficiencies associated with doing so.

Matter for Congressional Consideration

To eliminate unnecessary program duplication and to achieve increased efficiencies and potential savings within the integrated MHS, Congress should terminate the Secretary of Defense's authority to contract with the USFHP designated providers in a manner consistent with a reasonable transition of affected USFHP enrollees into TRICARE's regional managed care program or other health care programs, as appropriate.

Agency Comments

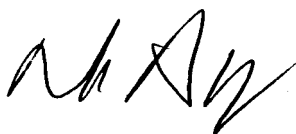
We provided a copy of this report to DOD for review and comment. DOD stated that since our recommendation to eliminate the USFHP is addressed to Congress, it defers to Congress to consider it. DOD also reiterated our statement that if the USFHP were to be eliminated, it will be important to make provisions to carefully transition USFHP enrollees to other health care programs.

In its response, DOD confirmed that our factual determinations about the USFHP are correct. DOD also provided specific comments on many of the program characteristics we identified, agreeing that they result in unnecessary costs and other inefficiencies for the department. In particular, DOD stated that the USFHP sole source contracts are an exception to congressional and DOD policy favoring competition in contracting. DOD also noted that the unnecessary duplication between the USFHP and MCSCs creates costs for the department, as necessary care is already provided through the MCSCs and the direct care system and that DOD is required to expend considerable resources in its annual negotiations with the designated providers to set capitation payment rates. DOD also stated that the separate existence of the USFHP is an exception to the general DOD policy of favoring an integrated MHS to support readiness and cost-effectiveness. DOD further acknowledged that the USFHP designated providers are allowed to offer their providers higher reimbursements and other incentives that draw beneficiaries away from the more cost effective MCSCs, which DOD characterized as an exception to congressional and DOD policy favoring a uniform TRICARE benefit.

DOD's comments are reprinted in appendix IV. DOD did not provide any technical comments.

We are sending copies of this report to appropriate congressional committees; the Secretary of Defense; the Assistant Secretary of Defense (Health Affairs); and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

A handwritten signature in black ink, appearing to read 'Debra A. Draper'.

Debra A. Draper
Director, Health Care

Appendix I: Past and Current US Family Health Plan (USFHP) Designated Providers

1994	2014
1. Martin's Point Health Care	Martin's Point Health Care
2. Brighton Marine Health Center	Brighton Marine Health Center
3. Bayley Seton Hospital	St. Vincents Catholic Medical Centers ^a
4. Johns Hopkins Medical Services	Johns Hopkins Medical Services Co.
5. Pacific Medical Center	Pacific Medical Centers
6. St. John Hospital	CHRISTUS Health
7. St. Joseph Hospital	CHRISTUS Health
8. St. Mary's Hospital	No longer a USFHP designated provider ^b
9. St. Mary Hospital	CHRISTUS Health
10. Lutheran Medical Center	Terminated its contract with the Department of Defense ^c

Source: GAO analysis of information from Department of Defense and USFHP designated providers. | GAO-14-684.

Note: The years reported in this table are calendar years and were selected to illustrate how the number of USFHP designated providers has changed over 20 years. While some USFHP designated providers have existed for this entire timeframe, some of their names have changed over the years.

^aOriginally known as Bayley Seton Hospital, this designated provider is now known as St. Vincents Catholic Medical Centers and owns and operates three health centers in New York: the Bay Ridge Family Health Center, the Mitchel Field Family Health Center, and the Fort Wadsworth Family Health Center.

^bCHRISTUS Health was formerly known as the Sisters of Charity Health Care System. Under that name, the health care system sold the St. Mary's Hospital (Galveston) to the University of Texas Medical Branch. St. Mary's (Galveston) is no longer part of CHRISTUS Health.

^cLutheran merged with Fairview Hospital in 1995, and in 1997 became part of the Cleveland Clinic Health System. Officials from the Department of Defense told us that this designated provider decided to end its USFHP contract with the department in 2007. Affected beneficiaries were transitioned to TRICARE or Medicare.

Appendix II: US Family Health Plan (USFHP) Designated Provider Characteristics

Designated Provider	Geographic Service Area	Total Number of USFHP Enrollees ^a
Johns Hopkins Medical Services Co.	Maryland, Washington, D.C., and parts of Delaware, Pennsylvania, Virginia, and West Virginia	41,752 (of which 8,602 are 65+)
Brighton Marine Health Center	Massachusetts, Rhode Island, and northern Connecticut	14,288 (of which 5,497 are 65+)
Martin’s Point Health Care	Maine, New Hampshire, Vermont, upstate and western New York, and the northern tier of Pennsylvania	41,991 (of which 12,573 are 65+)
CHRISTUS Health	Southeast Texas and southwest Louisiana	11,803 (of which 6,596 are 65+)
Pacific Medical Centers	Puget Sound area of Washington state	13,062 (of which 7,354 are 65+)
St. Vincents Catholic Medical Centers	New Jersey, New York City, southern New York, western Connecticut, and southeastern Pennsylvania	11,164 (of which 3,575 are 65+)

Source: GAO analysis of information and data from Department of Defense and the USFHP designated providers. | GAO-14-684

^aEnrollment as of October 2013.

Appendix III: Discounts and Services Offered by Designated Providers in Addition to the TRICARE Prime Benefit as of June 2014

Discount or Service	Brighton Marine Health Center	CHRISTUS Health	Johns Hopkins Medical Services Co.	Martin's Point Health Care	Pacific Medical Centers	St. Vincents Catholic Medical Centers
Vision Discounts ^a	✓	✓	✓	✓	✓	✓
Dental Discounts ^b		✓	✓			
Alternative Medicine Discounts ^c	✓		✓	✓	✓	
Hearing and Hearing Aid Discounts ^d	✓	✓	✓	✓		
Transportation ^e		✓		✓		✓
Nutrition or Fitness Discounts ^f	✓		✓	✓	✓	✓
Elective Cosmetic Surgery Discounts ^g			✓			
Infertility ^h Services Discounts			✓			

Source: GAO analysis of information from US Family Health Plan designated providers. | GAO-14-684

^aDiscounted vision services can include a free annual eye exam, discounts on glasses and lenses at select providers, or LASIK vision correction.

^bDental services offered by the designated providers can include a free initial exam plus a 15 percent discount on services.

^cServices offered at a discount under this category can include chiropractic care, acupuncture, yoga, and massage therapies.

^dDesignated providers offer a free annual hearing exam, plus discounts on hearing aids.

^eDesignated providers offer up to four round-trips (eight one-way) to approved covered medical services.

^fServices offered at a discount under this category can include nutritional counseling or gym memberships.

^gThis designated provider offers enrollees a \$500 discount on any procedure including anti-aging procedures, such as face lifts and rhinoplasty and a 15 percent discount on all injectables including Botox.

^hEnrollees receive an unspecified discount for all in vitro fertilization and intrauterine insemination procedures.

Appendix IV: Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

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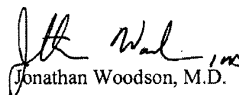
Debra Draper
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense's (DoD) response to the U.S. Government Accountability Office (GAO) Draft Report titled, "DEFENSE HEALTH CARE: U.S. Family Health Plan is Duplicative and Should be Eliminated (GAO-14-684)," GAO Code 291114 dated July 1, 2014.

Thank you for the opportunity to review and comment on the Draft Report. The GAO recommendation to eliminate the statutory requirement for the U.S. Family Health Plan is addressed to Congress and DoD defers to Congress to consider it. DoD believes GAO's factual determinations are correct. Our specific comments are enclosed.

The points of contact on this matter are Ms. Danielle McCammon (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Ms. McCammon may be reached at (703) 681-8675, or Danielle.McCammon@dha.mil. Mr. Zimmerman may be reached at (703) 681-4360, or Gunther.Zimmerman@dha.mil.


Jonathan Woodson, M.D.

Enclosure:
As stated

GAO-14-630

**DEFENSE HEALTH CARE: THE U.S. FAMILY HEALTH PLAN (USFHP) IS
DUPLICATIVE AND SHOULD BE ELIMINATED
(GAO-14-684)**

MATTER FOR CONGRESSIONAL CONSIDERATION:

To eliminate unnecessary duplication and to achieve increased efficiencies and potential savings within the integrated Military Health System (MHS), Congress should terminate the Secretary of Defense's authority to contract with the USFHP designated providers in a manner consistent within a reasonable transition of affected USFHP enrollees into TRICARE's regional managed care program or other health care program or other health care programs as appropriate.

DOD RESPONSE:

The GAO recommendation to eliminate the statutory requirement for the U.S. Family Health Plan is addressed to Congress and DoD defers to Congress to consider it. DoD believes GAO's factual determinations are correct. Specific comments follow.

- The USFHP operates essentially as a sole source contract earmark. This is an exception to the general Congressional and DoD policy favoring competition in contracting.
- We recognize that duplication exists as the USFHP provides the same TRICARE Prime benefit that is offered through the three regional managed care support contractors (MCSCs). Specifically, there is significant overlap with benefits, geographic service areas and provider networks. The duplication also adds cost, as necessary care is available through the MCSCs and the direct care system.
- DoD is unable to promote the efficient use of DoD's direct care system through the USFHP, as it operates independently of the integrated Military Health System (MHS) as a distinct statutory program. This is an exception to the general DoD policy favoring recapturing of care into MTFs as a means to support readiness and cost-effectiveness.
- The USFHP providers are not limited to the TRICARE provider reimbursement rates, and therefore have the flexibility to offer their providers higher rates and other incentives to render care. This creates a competitive advantage for the USFHP and draws beneficiaries away from the more cost effective MCSCs. Although this contributes to high beneficiary satisfaction rates, it is an exception to the general Congressional and DoD policy favoring a uniform TRICARE benefit.
- DoD is required to annually negotiate capitation payment amounts with each of the six USFHP providers, a process that lasts 8 months on average and requires DoD to expend considerable resources in developing data and committing personnel to the negotiations.

Should Congress decide to eliminate this statutorily-required program, it will be important to make provisions to carefully transition the 137,000 USFHP beneficiaries to other federal

programs. This includes Medicare-eligible beneficiaries and procedures to facilitate Part B enrollment for a small group of those not currently enrolled.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Kaitlin Coffey; Christine Davis; Sylvia Jones; Drew Long; Samantha Poppe; James Rebbe; and William T. Woods made key contributions to this report.

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